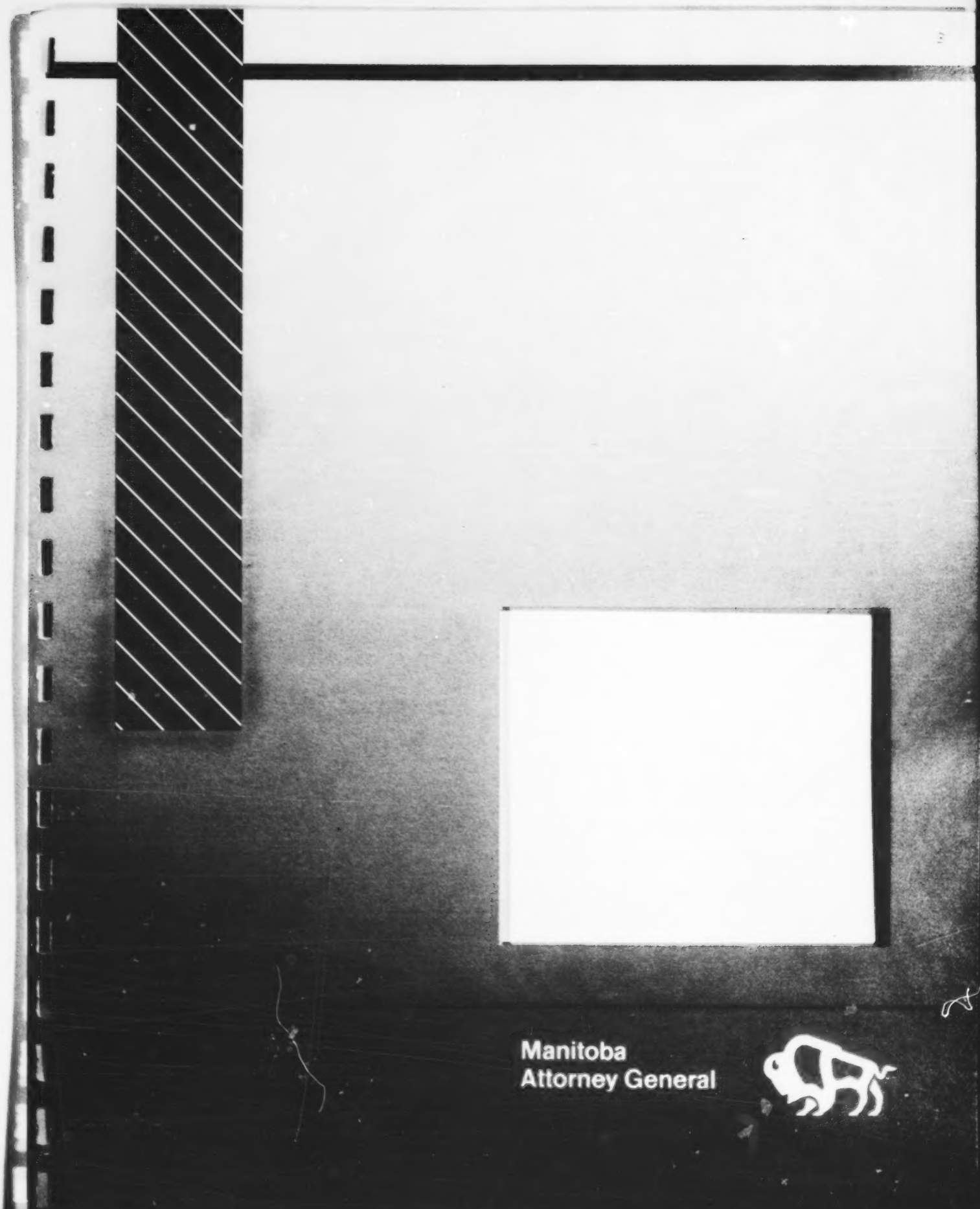
Manitoba
Attorney General

88-04644/

OFFICE OF
THE
CHIEF MEDICAL EXAMINER

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Chief Medical Examiner

ANNUAL REVIEW

1985

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HISTORICAL BACKGROUND

(Coroner System - Medical Examiner System)

The Medical Examiner and the Medical Examiner system has evolved from duties which were assigned to Coroners and systems put in place to effect the legislated and non-legislated responsibilities of the office. While the role of the coroner is historically ancient the functions of the medical examiner are of relatively recent origin.

The word coroner is a derivation from the old French spelling of the word "crown". The office of "Crowner" (crown representatives) was originally established to secure revenues which accrued to the crown in the event of sudden or unexplained deaths.

The first detailed statute on the office of coroner was the 1275 Statute of Westminister which established the office for revenue purposes. Subsequent British legislation shifted the coroner's responsibility to the investigation of deaths due to violence or unnatural means but retained the revenue aspect through a fee payable to the coroner for each inquest held.

Historically, Canada inherited the concepts of a Coroner and of a Coroner's inquest as part of the common law. The common law powers of a coroner to indict persons upon an inquisition for murder or manslaughter, to commit them for trial and to certify evidence were incorporated as part of the Canadian Criminal law in 1892, at which time the indictment function of the inquest was terminated.

The subsequent enactment of Provincial legislation established the jurisdiction and role of the Coroner and continued the coroner's functions of investigating deaths, empanelling juries and conducting inquisitions (inquests). In some provinces and territorial jurisdictions the coroner concept still remains.

It was as recent as 1971 that Manitoba enacted and proclaimed THE FATALITY INQUIRIES ACT to replace THE CORONER'S ACT. This statute was re-enacted in 1975 and with subsequent minor amendments, remains in force today.

The significant features of the current Act is the division of responsibilities into the medical and legal disciplines; the initial inquiry into the cause and manner of death being carried out by a duly qualified medical practitioner and the inquest, when deemed necessary, being conducted by a Provincial Judge without a jury.

This brief historical background has been provided to explain that in Manitoba the Medical Examiner system, while of relatively recent origin, has been both legislatively and operationally implemented and has fully replaced the Coroner system.

INTRODUCTION

The Office of the Chief Medical Examiner in Manitoba is responsible under the Fatality Inquiries Act and the Vital Statistics Act for the investigation and certification of all deaths by violence, as well as unexpected, unexplained or unattended deaths. Certain hospital and institutional cases, notably those of persons dying within ten days of surgery or anaesthesia, are investigated, as are deaths of persons held involuntarily.

The area of jurisdiction is the province of Manitoba, which has a population of approximately 1.1 million. In addition, the Medical Examiner has jurisdiction over those who travel through the province.

The medical examiner system, under the direction of the Chief Medical Examiner, is managed from a central office located in Winnipeg. The office administers the complete province of Manitoba and has a permanent staff of one administrative officer, two medical investigators and two administrative secretaries. The fee-for-service element is provided by approximately 73 part-time medical examiners with additional fee-for-service support provided by pathologists, funeral directors and ambulance services.

In the City of Winnipeg, two medical investigators are on duty daily Monday to Friday during standard working hours. Part-time medical examiners are available and on call during the evenings and weekends. Throughout rural Manitoba and in other cities such as Brandon, Thompson, etc., part-time medical examiners are available on an as-required basis 24 hours a day.

Toxicology testing is provided by the Royal Canadian Mounted Police Forensic Laboratory. Other speciality tests are provided on an as-required basis, utilizing outside resources both in and out of the Province of Manitoba.

In 1985, 2522 deaths were investigated by the Chief Medical Examiner's office. This represented approximately thirty per cent of all deaths in Manitoba during the year. In each case, the report generated by the medical examiner or medical investigator contained information on the cause, manner, and circumstances surrounding the death. In many cases the police, both RCMP and municipal forces, assist the medical examiners in conducting their investigations.

In January of 1985, the Office of the Chief Medical Examiner became actively involved in the eye donor program. Next of kin were contacted shortly after death and asked to consent to donating the cornea of the deceased. Through the program, eight pairs of eyes were made available to the Lions Eye Bank. This represented a positive response, and as a result it is planned to continue the program in 1986.

Caseload Statistics

TOTAL CASES

CERTIFIED CASES

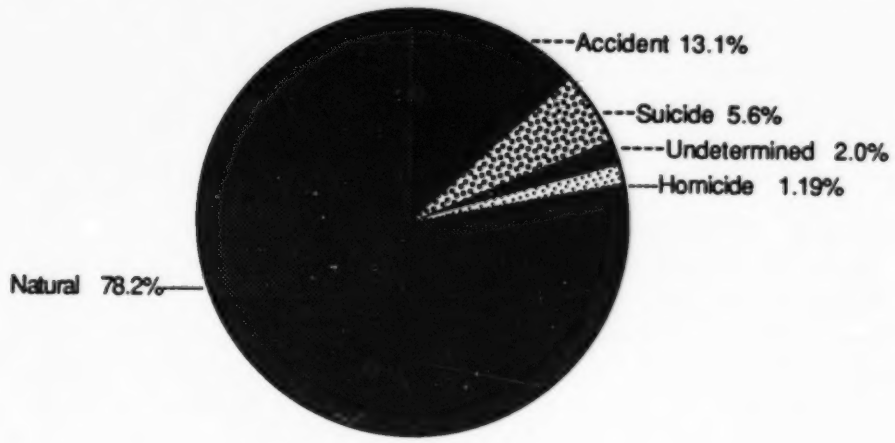
Manner of Death	Cases	Aggregate Rate per 100,000 population
Natural	1972	184.2
Accidents in the home	89	8.3
Accidents in other places	77	7.2
Industrial Accidents	20	1.9
Motor Vehicle Accidents	144	13.5
Suicides	141	13.2
Homicides	28	2.6
Undetermined	51	4.8
Total	2522	235.6

Note: 283 natural deaths were designated Medical Examiner's Investigators cases.

REGIONAL DISTRIBUTION OF CASES

	Urban	Rural	Total
Natural	1417	555	1972
Accidents in the Home	53	36	89
Accidents in other Places	19	58	77
Industrial Accidents	9	11	20
Motor Vehicle Accidents	46	98	144
Suicides	80	61	141
Homicides	20	8	28
Undetermined	34	17	51
TOTAL	1678	844	2522

MEDICAL EXAMINER CASES



CASELOAD REVIEW 1972 - 1985

YEAR	TOTAL
1972	2320
1973	2409
1974	2409
1975	2604
1976	2653
1977	2758
1978	2667
1979	2627
1980	2480
1981	2683
1982	2480
1983	2545
1984	2386
1985	2522

TYPES OF DEATH INVESTIGATED AND CERTIFIED

HOMICIDES

	Male	Female	TOTAL
Urban	17	3	20
Rural	6	2	8
TOTAL	23	5	28

AGE/METHOD

Method	Age: 0-9	10-19	20-29	30-39	40-49	50-59	over 60	TOTAL
Police	0	0	0	0	0	0	0	0
Blunt Weapon Violence	1	0	1	2	1	2	1	8
Firearms	0	0	2	0	1	0	0	3
Stabbing/ Incised Wound	0	2	4	2	1	2	2	13
Child Battery	0	0	0	0	0	0	0	0
Other	0	1	2	0	1	0	0	4
TOTAL	1	3	9	4	4	4	3	28

SUICIDES

AGE GROUP	MALE	FEMALE	TOTAL	RATE/100,000 POPULATION
0 - 9	0	0	0	0
10 - 19	14	1	15	1.4
20 - 29	36	3	39	3.6
30 - 39	20	8	28	2.6
40 - 49	9	1	10	0.9
50 - 59	15	7	22	2.1
60 - 69	13	5	18	1.7
70 - 79	3	3	6	0.6
80 - 89	2	1	3	0.2
OVER 90	0	0	0	0
TOTAL	112	29	141	13.2

REGION/MONTH

Month of Death	Urban	Rural	TOTAL
January	5	6	11
February	4	3	7
March	6	5	11
April	13	6	19
May	5	4	9
June	6	4	10
July	10	4	14
August	6	4	10
September	9	7	16
October	5	6	11
November	5	6	11
December	6	6	12
TOTAL	80	61	141

SUICIDES 1972 - 1985

1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
97	124	141	141	141	179	155	135	126	151	149	172	151	141

SUICIDE RATES PER 100,000 POPULATION BY YEAR

Year	Estimated Population (000's)	Total Suicides	Rate/ 100,000
1972	991.2	97	9.8
1973	996.2	124	12.5
1974	1,007.5	141	14.0
1975	1,013.6	141	13.9
1976	1,021.5	141	13.8
1977	1,027.4	179	17.4
1978	1,032.0	155	15.0
1979	1,028.0	135	13.1
1980	1,024.9	126	12.3
1981	1,026.2	151	14.7
1982	1,034.5	149	14.4
1983	1,048.1	172	16.4
1984	1,058.8	151	14.3
1985	1,070.6	141	13.2

METHOD

	Male	Female	TOTAL	PERCENTAGE OF TOTAL
Drug overdose/Poison	5	9	14	10%
Carbon monoxide	10	4	14	10%
Hanging/Strangulation	30	3	33	23%
Drowning	5	6	11	8%
Firearms	52	2	54	38%
Jumping	2	1	3	2%
Other	8	4	12	9%
TOTAL	112	29	141	100%

NATIONAL SUICIDE RATES* PER 100,000 POPULATION 1975 - 1985

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
National Rate	12.4	12.8	14.3	14.8	14.1	14.0	14.0	13.9	15.1	13.7	12.9
NFLD	3.5	3.8	3.7	2.6	4.4	3.4	4.2	6.0	6.2	6.7	4.0
PEI	11.9	19.5	10.0	13.1	13.1	11.4	7.4	8.9	12.9	12.0	3.9
NS	10.4	10.4	11.3	12.5	12.6	11.5	10.9	12.2	12.1	9.9	12.0
NB	8.0	10.9	10.5	12.9	12.1	11.6	11.1	12.9	14.2	12.6	12.0
QUE	9.3	10.5	12.4	14.2	15.4	14.8	16.4	16.5	18.5	15.7	17.1
ONT	13.5	13.0	14.5	14.3	13.0	13.1	12.5	12.7	12.9	12.3	11.4
MAN	13.1	14.1	17.5	15.4	14.7	11.8	14.0	13.4	15.8	12.7	11.9
SASK	14.9	14.0	15.6	17.3	14.9	15.9	17.7	17.5	14.9	13.5	13.0
ALTA	15.8	16.9	17.9	16.5	15.4	18.1	15.9	16.2	16.7	17.2	12.6
BC	16.9	16.4	17.6	18.3	16.2	14.8	14.5	15.0	14.8	13.4	10.4
YUKON**	1.9	1.8	2.4	3.2	2.7	5.0	2.2	2.9	3.6	2.3	3.5
NWT**	1.7	1.6	2.8	5.5	1.8	2.0	2.2	1.7	4.3	3.4	2.5

* Source: Statistics Canada

** Rates based on 10,000

TRAFFIC ACCIDENTS

Motor Vehicle

- Alcohol related	64
- Not alcohol related	80
TOTAL	144

Vehicle/Pedestrian	30	Vehicle/Train	2
Vehicle/Vehicle	50	Vehicle/Fixed Object	1
Single vehicle	39	Multiple vehicle	0
Snowmobile	1	Motorcycle	10
All terrain cycle	1	Vehicle/Motorcycle	6
Minibike/Off road	2	Other	2
Motorhome	0		
		TOTAL TRAFFIC FATALITIES	144

NON-TRAFFIC ACCIDENTS

A. INDUSTRIAL

Farming	4
Mining	5
Other	11
TOTAL	20

B. IN OTHER PLACES

Aircraft	7
Exposure	17
Drowning	34
Carbon monoxide poisoning	1
Falls	6
Hunting	2
Falling objects	2
Other	8
TOTAL	77

C. IN THE HOME

Falls	29
Asphyxia	13
Inhalation burning house	29
Burns/Scalding	6
Electrocution	1
Drugs/Alcohol	8
Inhalation (Sniffing)	0
Other	3
TOTAL	89

Total non-traffic accidents	186
TOTAL ACCIDENTAL DEATHS	**330**

NATURAL DEATHS

CAUSE OF DEATH	MALE	FEMALE	TOTAL
Heart	820	387	1207
Cancer	72	40	112
Lung	124	73	197
Haemorrhage	105	54	159
Operative	12	4	16
Post-operative	55	49	104
Sudden Infant Death Syndrome	15	8	23
Stillborn	3	0	3
Undetermined	11	7	18
Other	78	55	133
TOTAL	1295	677	1972

AGE GROUP	MALE	FEMALE	TOTAL
under 1 year	34	15	49
1 - 9	9	8	17
10 - 19	5	2	7
20 - 29	12	4	16
30 - 39	26	13	39
40 - 49	65	16	81
50 - 59	168	68	236
60 - 69	342	138	480
70 - 79	408	184	592
80 - 89	182	168	350
90 - 99	33	57	90
over 100 years	1	2	3
unknown	10	2	12
TOTAL	1295	677	1972

SUDDEN INFANT DEATH SYNDROME

AGE GROUP	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
0 - 4 Months	0	1	1	3	1	0	5	0	0	1	2	2
5 - 8 Months	1	0	1	0	1	0	0	0	1	0	1	0
9 - 12 Months	0	0	0	0	0	0	0	0	0	1	0	1
TOTAL	1	1	2	3	2	0	5	0	1	2	3	3

In Manitoba S.I.D.S. accounted for 23 infant deaths in 1985. The overall incidence of S.I.D.S. have been reported as 1 case per 1,000 live births. Although it can occur at any time during the first year of life, the peak incidence in Manitoba is during the first four months.

S.I.D.S. STATISTICS 1972-1985

1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985
10	32	33	31	32	34	23	21	23	34	22	28	22	23

UNDETERMINED* DEATHS

CAUSE OF DEATH	MALE	FEMALE	TOTAL
Asphixia	4	0	4
Carbon monoxide poisoning	7	1	8
Drowning	5	0	5
Drugs/Alcohol overdose	14	6	20
Falls	1	1	2
Other	8	4	12
TOTAL	39	12	51

* Undetermined whether accidental, suicide, or homicide

INQUESTS

INQUESTS SUMMARY
(January 1, 1985 - December 31, 1985)

Judicial Recommendations For the Prevention of Similar Deaths

Manner of Death	Given	Not Given	
Natural	1	0	
Homicide	0	0	
Suicide	2	3	
Accident	9	8	
Undetermined	2	0	
TOTAL	14	11	25

TYPE OF INQUESTS

A. HOSPITAL/INSTITUTIONAL RELATED

Accidental	3
Suicide	1
Undetermined	1
TOTAL	5

B. OCCUPATIONAL RELATED

Acccidental	11
TOTAL	11

C. POLICE/INCARCERATION RELATED

Suicide	4
Undetermined	1
TOTAL	5

D. SPORTS/RECREATIONAL RELATED

Accidental	1
TOTAL	1

E. OTHER

Natural	1
Accidental	2
TOTAL	3

TOTAL INQUESTS 25

Summary of Inquests and Recommendations

(All deaths occurred in 1985)

Case	Description	Judicial Recommendations
1. Multiple injuries with massive brain maceration	Accidental. Mine worker who fell about 590 meters down a mine shaft from a moving conveyance. This occurred at the Spruce Point Mine near Snow Lake.	1) Increased supervision and training of cage tenders; 2) Only qualified ticketed personnel to operate a cage or a skip; 3) Post signs warning of requirement to close doors when conveyance is used for carrying person; and 4) Management and labour be brought to appreciate that swift and sure disciplinary action will be taken if conveyance or other dangerous equipment in mines are used in other than the prescribed manner.
2. Severe 2nd and 3rd degree body burns.	Accidental. An unexplained fire erupted while an INCO employee was investigating an oil leak in equipment. This occurred at the INCO Refinery, Thompson.	None.
3. Asphyxia, strangulation	Accidental. A mentally retarded child resident of the St. Amant Centre who was placed in a restraint device and put to bed.	None.
4. Acute complications resulting from heat stroke (Hyperthermia)	Accidental. A CNR employee who collapsed while working on the rail line in temperatures of 27 degrees C. This occurred near Baldur.	None.

Case	Description	Judicial Recommendations
5. Asphyxia, drowning	Accidental. A child playing near Kinsmen Park Swimming Pool out of season. The pool, although not in operation, contained approximately two meters of water. This occurred in Brandon.	1) The City of Brandon might consider inspections of pool security (two or three time a week before freeze up and after thaw) confirmed by entry in a log book kept for that purpose; and 2) The City of Brandon look into the feasibility of pool covers for its facilities as are presently used in the City of Winnipeg.
6. Asphyxia, drowning	Accidental. Patient with his Behaviour Specialist and another patient from the Grace Hospital, undergoing therapy at the St. James Centennial Pool.	None.
7. Asphyxia, drowning	Accidental. Deceased was on a supervised school field trip to the Birds Hill Provincial Park.	1) Closer liaison between Park and and School officials so that emergency procedures are understood and followed by parties, particularly schools making use of public parks with water facilities, with large numbers of children; and 2) Better identification of students attending in groups so as to make periodic counts more efficient, as well as some means of determining non-swimmers so that their activities near or in water are more visible and easier to supervise, such as identifying a safe area for non-swimmers only.
8. Asphyxia, hanging	Suicide. Deceased was a compulsory patient at the Brandon Mental Health Centre.	None.
9. Asphyxia,	Suicide. Deceased was an inmate of the Winnipeg Remand Centre.	1) A total review of the "correctional system" as it relates to matters raised in this Inquiry should be undertaken so that the questions raised and the errors made are eliminated: 2) A policy should be established so that the complete medical file of an inmate follows that inmate from correctional facility to correctional facility;

Case	Description	Judicial Recommendations
		3) The standing orders of the Winnipeg Remand Centre must be reviewed and clarified so as to remove the deficiencies and ambiguities that are present in the existing standing orders. Potential suicides should be dealt with as a separate matter in the standing order; 4) The present policy of the Winnipeg Remand Centre to broaden the education of the staff is to be encouraged. Specifically, courses on suicide prevention, crisis intervention and behavioural disorders should be designed so that they specifically relate to correctional institutions; 5) As a matter of precaution, courses should be arranged for the nursing staff so that they may improve their technique of interviewing, questioning and assessing inmates at the time of admission. Steps should be taken to ensure that the nursing staff has sufficient time to adequately interview and assess the newly arrived inmate. Those inmates who are identified as needing a more detailed interview should be given a thorough psychiatric investigation; and 6) Peer group discussions should be established so as to improve the ability of the staff to observe and assess inmates.

Case	Description	Judicial Recommendations
10. Overdose of Halothane	Accidental. Deceased was administered Halothane in addition to another anesthetic, in connection with an elective cholecystectomy for cholelithiasis, that is, a routine non-emergency gall bladder surgical procedure for the removal of stones. This occurred at the Misericordia Hospital.	1) That all health care institutions where the services of an anesthetist are required impose the duty of some person qualified to gain access into an operating room in use, of visually monitoring the controls of the anesthetist's equipment. This would entail necessary instructions to any such persons as to the proper positioning of all controls, and 2) Exploring the feasibility of attaching an oxygen analyzer to the tube connecting the vaporizer with the patient for the purpose of enabling the anesthetist to analyze the contents of the oxygen on an ongoing basis as it is induced into the patient.
11. Extradural hematoma due to cerebral herniation	Undetermined. Deceased was apprehended under the Intoxicated Persons Detention Act and lodged in the Main Street Project. One hour later he was found unconscious and transferred to the Health Sciences Centre where he died post-operatively.	1) The establishment of a nurse practitioner program within the confines of the Main Street Project and affiliation with an existing primary health care facility; 2) The Alcohol Foundation of Manitoba should increase its funding so that the I.P.D.A. program can be developed with better accommodations and the provision of professional staff; and 3) Set up more intensive in-house training so as to cope with the interpretation of vital signs and other matters that would be able to anticipate complications that could be dealt with in an appropriate way.
12. Asphyxia, due to crush injury	Accidental. Mine worker who was crushed by 75 tons of rock at the 3700 foot level. This occurred at the Stall Lake Mine near Snow Lake.	None.
13. Asphyxia, hanging	Suicide. Deceased was being held in legal custody by the RCMP in Flin Flon.	None.

Case	Description	Judicial Recommendations
14. Electrocution	Accidental. A Manitoba Hydro employee who was changing an insulator on top of a wooden hydro pole near Altona.	None.
15. Asphyxia, hanging	Suicide. Deceased was an inmate of Stony Mountain Penitentiary.	None.
16. Crushing traumatic injuries of the skull	Accidental. Mine worker who was thrown through the air as the result of a tremendous air blast. The deceased landed in the path of a vehicle. This occurred at the Fox Lake Mine near Lynn Lake.	None.
17. Near-drowning with acute aspiration bronchopneumonitis and hypoxemia	Accidental. Deceased, who was mentally handicapped, jumped or fell from a train bridge into the Red River. She was rescued and subsequently died in the Concordia Hospital.	1) That the Harbour Master be directed to ensure that there be two persons in their boat at all times; 2) That the Harbour Master be directed to ensure that at all times in addition to the equipment on the boat on the day in question there be at least oxygen-administering equipment; 3) That the Harbour Master ensure that at all times at least one of two persons on the boat have adequate life-guard training with the ability to administer oxygen and cardiac pulmonary resuscitation; and 4) Remove the word "Police" from the sides of the Harbour Master boat in view of the S.119 of the Criminal Code of Canada or ensure that the Harbour Master and at least one of the two persons in the Harbour Master boat be duly appointed peace officers.
18. Traumatic skull fracture	Accidental. Deceased was struck on the head while inflating a split rim tire which exploded.	1) That the Province of Manitoba examine the Occupational Health and Safety Act and regulations for industrial establishments contained in the revised statutes of Ontario (Chapter 321, 1980) and the Industrial Health and Safety Regulations of British Columbia

Case	Description	Judicial Recommendations
		(regulation 26.46) with the intent of introducing similar regulations in Manitoba; 2) That guidelines similar to the Safety Bulletin of January, 1986 be distributed to all shops where tire repair is not an integral part of operation; and 3) That all shops from which trucks are being operated and all trucks in operation in the Province of Manitoba be provided with a copy of the guidelines.
19. Acute severe bronchospasm attack	Natural. The deceased, an asthmatic, died shortly after ingesting a prescribed beta-blocker called "Blocadren".	1) That when giving a patient a drug sample, or a prescription, the doctor should write out specific instructions for the patient on how or when to take the medication, especially in cases where the patient appears to be in a nervous or agitated state; 2) That a doctor should keep a proper and complete record of all medication he gives to or prescribes for a patient; 3) That a doctor ought to keep sample drugs in such a place and in such a manner that they can be easily identified. In this particular case, it appears that all sample drugs were kept together in one drawer with no separation of dangerous and non-dangerous drugs; 4) That in cases such as the present one, doctors should co-operate fully with the medical examiner in order to allay the fears and suspicions of the family and the community, and to also maintain the integrity of the medical profession; and 5) Those involved in teaching at medical schools and lecturing at seminars ought to alert the medical profession as to the inherent danger in giving or prescribing certain types of drugs to their patients.

Case	Description	Judicial Recommendations
20. Asphyxia, hanging	Suicide. Deceased was in custody of the Winnipeg Police Department.	1) That the police procedures be reviewed and emphasized to every member of the Winnipeg Police Force to the end that every police officer be impressed with the duty (stressful conditions notwithstanding) in situations where members of the Police Department may be involved or where the place is a correctional institution, gaol or prison, or any institution in the Province where a person is an involuntary resident, that extraordinary attention be observed to securing the premises and securing the scene intact to allow for an independent investigation by the medical examiner, according to his duty under the Fatality Inquiries Act, and if the circumstances in the opinion of that medical examiner so dictate, for an independent investigation by another police force such as the RCMP; and 2) That in view of the experience here, the preferable procedure would seem to be that the sergeant on duty or some other senior officer within the Police Force be entrusted with the duty of actually communicating to the medical examiner or chief medical examiner as to death by violence and the place of violence.
21. Crushing injuries to skull and brain	Accidental. Deceased was caught under a collapsed hydraulic hoist.	1) That the appropriate Department of Government ensure that inspections are made of hydraulic hoists performing similar tasks at such times and in such manner that the public can be assured that each such device in use is capable of safe operation.
22. Multiple fractures and fragmentation of the skull with multiple cerebral lacerations	Accidental. Deceased was working as a forklift operator in a warehouse when a portion of the shelving holding large bales of paper collapsed and fell upon him.	1) That the company impose a system of forklift training with the Safety Council; and 2) That forklift operators apply the same amount of caution to their job as required for any kind of position that has a certain amount of danger involved in it and that all reasonable precautions must be taken by them not only to protect

Case	Description	Judicial Recommendations
		themselves but to protect others and to make sure that these kind of situations don't take place where something is dislodged and left to create a dangerous situation.
23. Multiple injuries	Accidental. Mine worker who fell 185 feet while working at the Spruce Lake Mine near Snow Lake.	1) That no one without rise (development) mining experience be allowed to work in such areas; and 2) More effective supervision of inherently dangerous areas be carried out on a regular programmed basis.
24. Inanition	Undetermined. Deceased was a resident of a residental care facility at the time of his demise. He had been a resident since 1981.	1) A medical/legal panel should be formed which would be empowered to consider the issue of placement where there seems to be a basis for moving an individual from one level of care to another, and where that individual, while mentally competent, has refused to accept the change in placement; 2) That recommendations for placement into a personal care home should not only be the responsibility of a duly qualified physician but that recommendation should be considered from other disciplines such as social workers, nurses, etc.; and 3) That consideration be given to the enactment of a Dependent Adults Act.
25. Crush injuries	Accidental. Mine worker who was pinned between a wall and a moving slag pot while descending a ladder. This occurred at the Hudson Bay Mining and Smelter, Flin Flon.	None.